STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005043	A. BUILDING: _____ B. WING _____	C 08/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH HOSPITAL	700 BROADWAY FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one State hospital complaint. Complaint Number: IN00178608 Unsubstantiated; lack of sufficient evidence Date: 8/25/15 Facility Number: 005043 St. Joseph Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff and 410 IAC 5-1.5-6, Nursing Services, Indiana Hospital Licensure Rules. QA: cjl 09/01/15	S 000		